

Please write legibly. All fields are required.

Policy Holder Information

Policy Holder Name		Person ID Number
Current Payer Name		Current Payer Person ID Number
Postal Address		ZIP Code
Phone Number	E-Mail	

New Payer Information

New Payer Name	Person ID Number	
Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Phone Number	E-Mail	
Postal Address		ZIP Code
Relationship with the Current Payer		

<input type="checkbox"/> EFT Payment (ACH) <input type="checkbox"/> Credit Card Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi Annual <input type="checkbox"/> Annual

Bank information

<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account number:	ABA routing number:
Name of Financial Institution:		

<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	Card number:	Security Code (CVC):
Expiration date: MM/AAAA	Name on the card:	

Please write legibly. All fields are required.

I hereby state that all the answers and statements contained herein are complete in details and are true.	Signed in
	Date MM / DD / YYYY

IMPORTANT NOTICE

Any person who knowingly and with the intention of damaging, committing fraud or deceiving an insurer submits a claim or request that contains false, incomplete or misleading information is guilty of a third degree felony.

New Payer's Signature

Policy Holder's Signature

FOR OFFICE USE ONLY

Processed by: _____

Date: _____